

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN7202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2010
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF RHEA COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  During the annual survey conducted from November 1-3, 2010, complaint #TN00025623, was investigated. No deficiencies were cited with Chapter 1200-8-6 Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

*Kate Lufford*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

EXECUTIVE DIRECTOR  
TITLE

11/18/10  
(X6) DATE

STATE FORM

6899

8UL711

If continuation sheet 1 of 1